

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 19 December 2006

CASE NO.: 2004-BLA-5782

In the Matter of

V. M. E., o/b/o
W. J. E. (Deceased)
and Widow of
W. J. E.,
Claimant

v.

EASTERN ASSOCIATED COAL CORPORATION
Employer

And

OLD REPUBLIC INSURANCE COMPANY,
Carrier

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Frederick K. Muth, Esq.,
For the Claimant

Paul E. Frampton, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

**DECISION AND ORDER AWARDING LIVING MINER'S BENEFITS, DENYING
SURVIVOR'S BENEFITS, AND DENYING AUGMENTATION OF BENEFITS FOR
MINER'S ADULT SON**

This proceeding arises from a consolidated modification request concerning a living miner's subsequent claim for benefits and survivor's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.*, as amended ("Act"). The living miner's claim was filed on October 5, 1999; the survivor's claim was filed on April 24, 2002.¹ The Act, and implementing Regulations, 20 C.F.R. parts 410, 718, and 727 ("Regulations"), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The living miner's claim is the miner's third claim for benefits under the Act. He filed his first claim on July 1, 1981. On January 15, 1982, the District Director denied that claim, finding that the evidence failed to establish that the miner was totally disabled due to pneumoconiosis. Thereafter, the miner requested a reconsideration of this decision. On May 6, 1983, the District Director issued another decision, indicating that its initial finding of non-entitlement stood. On May 9, 1983, the miner requested a hearing before an Administrative Law Judge. The claim was referred to the Office of Administrative Law Judges ("OALJ") on November 14, 1985. After conducting a hearing on June 23, 1988, the Honorable Rudolph L. Jansen issued a Decision and Order denying benefits, dated December 29, 1988. Judge Jansen denied the claim primarily because the miner failed to establish the presence of a totally disabling respiratory or pulmonary impairment. (LM DX 1).

The miner filed his second claim for benefits on March 16, 1990. On September 11, 1990, the District Director denied the claim, finding that the miner failed to establish total disability due to pneumoconiosis and, correlatively, that no material change in condition had occurred since the previous denial. The miner took no further action in pursuit of this claim. (LM DX 2).

¹ Because it was filed after January 19, 2001, the Regulations, as amended in 2001, shall apply *in toto* to the survivor's claim. Pursuant to 20 C.F.R. § 725.2(c)(2001), because the living miner's claim was filed before January 19, 2001, the amended Regulations shall also apply to it, with the exception of the following sections: §§ 725.101(a)(31), 725.204, 725.212(b), 725.213(c), 725.214(d), 725.219(d), 725.309, 725.310, 725.351, 725.360, 725.367, 725.406, 725.407, 725.408, 725.409, 725.410, 725.411, 725.412, 725.414, 725.415, 725.416, 725.417, 725.418, 725.421(b), 725.423, 725.454, 725.456, 725.457, 725.458, 725.459, 725.465, 725.491, 725.492, 725.493, 725.494, 725.495, 725.547, and 725.701(e). Those sections as set forth in the pre-Amendment version of the Regulations shall apply to the living miner's claim.

The miner filed his third claim for benefits on October 5, 1999. The District Director found the miner was entitled to benefits on June 16, 2000. The Employer contested this decision and requested a hearing before an Administrative Law Judge. The Honorable Daniel L. Leland conducted a hearing on August 2, 2001 in Beckley, West Virginia. Judge Leland issued a Decision and Order awarding benefits, dated November 19, 2001. (LM DX 66). In addition to finding that the miner had established a material change in conditions and the elements of entitlement, Judge Leland found that the miner's adult son, C.E., is disabled for the purpose of augmentation of benefits.

On December 21, 2001, the Employer appealed Judge Leland's decision to the Benefits Review Board ("BRB" or "Board"). On December 19, 2002, the Board issued a Decision and Order, in which it affirmed in part and vacated in part Judge Leland's decision. The Board affirmed Judge Leland's finding of a material change in condition based on a finding of total disability. It also rejected the Employer's objections to Judge Leland's discrediting of Drs. Branscom and Zaldivar, and crediting of Drs. Boustani and Rasmussen, concerning disability causation. The Board, however, vacated Judge Leland's finding concerning the existence of pneumoconiosis. Specifically, the Board held that Judge Leland did not indicate the weight and credibility to be assigned to four readings- those of Drs. Skeen, Shipley, Wheeler, and Scott- of a March 14, 2000 CT scan. It also held that Judge Leland did not indicate his reasoning for crediting the medical opinions of Drs. Daniel, Starr, Craft, Rasmussen, Boustani, and the West Virginia Occupational Pneumoconiosis Board, all of which supported a finding of pneumoconiosis. The Board, therefore, ordered this Court to weigh and assign credit to the CT evidence and reconsider the medical opinion evidence of record. Accordingly, the Board further instructed that after this Court does so, it must weigh all the evidence concerning the existence of pneumoconiosis together, consistent with the mandate of *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).² The Board also vacated Judge Leland's finding that the miner's adult son is disabled, which had resulted in the augmentation of benefits to him. To that end, the Board found that Judge Leland based his finding solely on a Social Security Administration determination of disability but that this determination did not include an evidentiary basis for its conclusion. Therefore, the Board instructed this Court, on remand, to set forth an evidentiary basis for such a finding, should benefits be awarded in the miner's claim.

On May 5, 2003, Judge Leland issued a Decision and Order on Remand awarding benefits. (LM DX 85). In addressing the Board's mandate concerning the CT evidence, Judge Leland found that, although a majority of readers found the March 14, 2000 CT scan to be negative, this fact was less probative than the X-ray evidence due to the high number of X-ray readings of record. Furthermore, in reconsidering the medical opinion evidence, Judge Leland found the opinions of Drs. Daniel, Starr, Craft, Rasmussen, Boustani, and the West Virginia Occupational Pneumoconiosis Board to be well-reasoned and well-documented and, therefore, entitled to credit. In considering the evidence in concert, under *Island Creek*, Judge Leland again concluded that the miner had established existence of pneumoconiosis. In addressing the Board's mandate concerning the disability of the miner's adult son, Judge Leland again found him to be disabled. He based this finding largely on the Social Security determination and the

² On the issue of existence of pneumoconiosis, however, the Board specifically rejected the Employer's contention that Judge Leland improperly weighed the X-ray evidence.

miner's testimony at the August 28, 1997 hearing. Therefore, Judge Leland again found the miner to be entitled to benefits and that benefits should be augmented for his son, C.E.

On May 27, 2003, the Employer filed a Motion for Reconsideration, requesting specifically that Judge Leland reconsider his decision to augment benefits for the miner's adult son. On June 9, 2003, Judge Leland issued a Decision and Order denying the Employer's Motion for Reconsideration.

On July 3, 2003, the Employer appealed Judge Leland's May 5, 2003 and June 9, 2003 decisions to the Board. Thereafter, the Employer filed a Motion to Dismiss without Prejudice and Remand to the District Director for Modification, which the Board granted by Order dated September 3, 2003.

On August 13, 2003, the Employer submitted to the District Director a Petition Modification and Consolidation with the Survivor's Claim. In support of its Petition for Modification, the Employer argued that both Judge Leland's award of benefits and finding of disability of the miner's adult son were based on mistakes of fact. On November 14, 2003, the District Director issued an order consolidating the modification request with the survivor's claim for benefits. It also ordered that the modification request be referred to OALJ, as this Court has jurisdiction to consider the issue of a mistake in determination of fact. The matter was referred to this Court on February 9, 2004.

The miner died on April 7, 2002. On April 24, 2002, his widow, V.M.E., filed a survivor's claim for benefits. On October 27, 2003, the District Director issued a Proposed Decision and Order awarding benefits. The District Director found that the miner had pneumoconiosis, which arose out of his coal mine employment, and caused his death, within the meaning of the Regulations. (WM DX 21). On October 29, 2003, the Employer contested this decision and requested a hearing before an Administrative Law Judge. Along with the consolidated modification request in the living miner's claim, the District Director referred this claim to OALJ on February 9, 2004. After three continuances were issued, I was assigned the case on January 3, 2006.

On May 9, 2006, I conducted a hearing in Beckley, West Virginia, at which the Claimant and Employer were both represented by counsel. No appearance was entered for the Director, Office of Workers' Compensation Programs ("OWCP"). The parties were afforded the full opportunity to present evidence and argument.

Because the living miner's claim was filed prior to January 19, 2001 but the survivor's claim was filed subsequent to that date, the evidentiary limitations found at 20 C.F.R. § 725.414 (2001) govern the admission of evidence the survivor's claim but not the living miner's claim. Moreover, the presence of the living miner's claim does not allow for any additional evidence beyond these limitations to be submitted in the survivor's claim. *See Church v. Kentland-Elkhorn Coal Corp.*, BRB No. 04-0617 BLA (Apr. 8, 2005)(unpublished) (holding that the evidence from a previously filed living miner's claim is not automatically admitted in a subsequently filed survivor's claim). Therefore, the admission of evidence for each claim is addressed separately.

In the living miner's claim, Employer's exhibits (LM EX) 1-2 and 4-13³ and Director's exhibits (LM DX) 1-105 were admitted into evidence.⁴ I excluded as cumulative the exhibit proffered as LM DX 3. Additionally, prior to one of the previous continuances issued in this case, the Employer had submitted to this Court the April 11, 2005 deposition of Dr. Ben Branscom. Although that exhibit was not discussed at the hearing, I admit it as LM EX 14. The Claimant proffered no additional exhibits in the living miner's claim. In the survivor's claim, Claimant's exhibit (WM CX) 1, Employer's exhibits (WM EX) 5 and 7-11⁵, and Director's exhibits (WM DX) 1-29 were admitted into evidence. I withheld ruling on the admission of exhibits proffered as WM EX 1-2. I initially did not admit WM EX 3 as both cumulative and in excess of the evidentiary limitation of 20 C.F.R. § 725.414. I did not admit the exhibits proffered as WM EX 4 and 6 because they exceeded the Employer's limit of submitting one CT scan in support of its affirmative case.⁶

The exhibits proffered as WM EX 1 and 2 each contain a series of five X-ray interpretations. Because the Regulations as amended in 2001 apply to the survivor's claim, the Employer is limited to submitting no more than two chest X-ray interpretations in support of its affirmative case. 20 C.F.R. § 725.414(a)(3)(i).⁷ At the hearing, the Employer requested that WM EX 1-3, which together contain 14 interpretations of five X-rays, be admitted, irrespective of the evidentiary limitations, for good cause.⁸ The Employer indicated that he intended to develop an argument, through the submission of post-hearing evidence, that admission of a series of readings is necessary to support portions of its theory of the case, namely that the miner had idiosyncratic pulmonary fibrosis rather than pneumoconiosis. (Transcript ("TR") 27). I indicated that I would consider the argument after the submission of post-hearing evidence. In considering the argument now, I find that good cause has not been established for the submission of excess interpretations. To that end, Drs. Fino and Renn each stated that serial readings of X-rays may be helpful in certain circumstances to more accurately arrive at medical conclusions (*see* LM EX 11B/WM EX 10B at 13; LM EX 9/WM EX 9 at 17). However, they have not specifically related the need for additional X-rays to this particular case. Thus, the Employer has not established good cause for admitting evidence in excess of the regulatory prescribed evidence limitations. Therefore, the Employer is limited the submission of two X-ray interpretations.

In its Closing Argument, the Employer stated that in the event I would deny his good cause request, he designated a January 31, 2001 reading by Dr. Scott (originally proffered as part of WM EX 3) and an April 16, 2001 reading by Dr. Scatarige (originally proffered as part of WM EX 2) as its two affirmative interpretations. I admit these two exhibits. For the sake of

³ The exhibit proffered as LM EX 11 contains two documents- a medical report authored by Dr. Renn and the transcript of Dr. Renn's September 15, 2006 deposition. The medical report is labeled LM EX 11A and the deposition transcript is labeled LM EX 11B.

⁴ As noted below, the X-ray readings contained in LM EX 1 and 2 are individually labeled (a) through (e).

⁵ As is true in the living miner's claim, the exhibit proffered as WM EX 10 contains both the medical report and deposition transcript of Dr. Renn. The medical report is labeled WM EX 10A and the deposition transcript is labeled WM EX 10B.

⁶ *See Webber v. Peabody Coal Co.*, BRB No. No. 05-0335 BLA (BRB Jan. 27, 2006) at 7-9.

⁷ Additionally, because the Claimant has not submitted any interpretations in support of her affirmative case, the Employer is not entitled to the submission of rebuttal readings.

⁸ *See* 20 C.F.R. § 725.456(b)(1).

simplicity, these exhibits retain their original numerical designations. Therefore, I revise my evidentiary ruling at the hearing concerning the Employer's evidence in the survivor's claim as follows:

- (a) WM EX 1 is excluded;
- (b) WM EX 2 is admitted but limited to Dr. Scatarige's April 16, 2006 reading;
- (c) WM EX 3 is admitted, but limited to Dr. Scott's January 31, 2006 reading;
- (d) WM EX 4 and 6 are excluded;
- (e) WM EX 5 and 7-11 are admitted.

ISSUES

- I. Whether the miner had pneumoconiosis, as defined by the Act and Regulations?
- II. Whether the miner's pneumoconiosis arose out of his coal mine employment?
- III. Whether the miner was totally disabled?
- IV. Whether the miner's disability was due to pneumoconiosis?
- V. Whether the miner's death was due to pneumoconiosis?
- VI. Whether there has been a mistake in the determination of fact with respect to the living miner's claim?
- VII. Whether the miner's adult son is a dependent for the purpose of augmentation of benefits?

FINDINGS OF FACT

I. Background

A. Survivorship⁹

⁹ 20 C.F.R. § 725.212 puts forth the following as conditions of entitlement for a surviving spouse:

(a) An individual who is the surviving spouse or surviving divorced spouse of a miner is eligible for benefits if such individual:

- (1) Is not married;
- (2) Was dependent on the miner at the pertinent time; and
- (3) The deceased miner either:
 - (i) Was receiving benefits under section 415 or part C of title IV of the Act at the time of death as a result of a claim filed prior to January 1, 1982; or,
 - (ii) Is determined as a result of a claim filed prior to January 1, 1982 to have been totally disabled due to pneumoconiosis at the time of death or to have died due to

The parties have agreed and I find that the Claimant, V.M.E., is an eligible survivor of the miner. (TR 9).

B. Coal Miner

The parties have agreed and I find that the miner was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for 34 years. (TR 9-10).

C. Date of Filing

The miner filed his claim for benefits on October 5, 1999; the Claimant filed the survivor's claim for benefits on April 24, 2002. The issue of timeliness was not contested and I find that none of the Act's filing time limitations are applicable; thus, both claims were timely filed.

D. Responsible Operator

Eastern Associated Coal Corporation is the last employer for whom the miner worked a cumulative period of at least one year and agreed that it is the properly designated responsible coal mine operator in this case, under Subpart F of the pre-Amendment Regulations and Subpart G of the post-Amendment Regulations, as applicable to the respective claims considered herein. (LM DX 4; WM DX 3; TR 10).

E. Dependents

It is uncontested, and I find, that the miner's wife qualifies as a dependent for the purpose of augmentation of benefits, with respect to the living miner's claim. However, the Employer has contested the dependency of the miner's adult son, as it relates to both claims. For the reasons discussed *infra*, I find that the miner's adult son does not qualify as a dependent for the purpose of augmentation of benefits.

F. Personal, Employment, and Smoking History

The miner was born on April 19, 1925. (WM DX 2; LM DX 3). He married the Claimant on April 30, 1951. (LM DX 8). It has been stipulated that the miner worked in the coal mines for 34 years. (TR 9-10). During his career, the miner worked as a coal loader, brakeman, hoist operator, motorman, machine operator, and beltman. (LM DX 4). His last position was that of a beltman. (LM DX 65 at 25). The miner testified that this position involved heavy exertion. (LM DX 65 at 25). His coal mine employment ended in April 1980

pneumoconiosis. A surviving spouse or surviving spouse or surviving divorced spouse of miner whose claim is filed on or after January 1, 1982, must establish that the deceased miner's death was due to pneumoconiosis in order to establish entitlement to benefits, except where entitlement is established under § 718.306 of part 718 on a claim filed prior to June 30, 1982.

and he did not work after that. (LM DX 65 at 24-25). The miner died on April 7, 2002. (WM DX 2).

The miner testified that he never smoked cigarettes but had smoked cigars for several months in 1943. (LM DX 65 at 30).

II. Medical Evidence

I incorporate by reference the summary of evidence contained in Judge Leland's November 19, 2001 Decision and Order. The following is a summary of the evidence submitted since the issuance of that decision.

A. Chest X-rays and CT Scans

Chest X-Rays

As noted above, LM EX 1 and LM EX 2, which each contain a series of X-ray readings, are admitted in the living miner's claim. The following table contains a summary of those readings.

Exhibit Number	Dates: X-ray/ Reading	Reading Physician	Radiological Qualifications¹⁰	Film Quality	ILO Classification, Interpretation, or Impression
LM EX 1(a)	1/31/01 10/31/03	Wheeler	B-Reader Board Certified	3	No abnormalities consistent with pneumoconiosis; minimal to moderate interstitial infiltrates or interstitial fibrosis mixed with tiny blebs or cysts; arteriosclerosis aortic arch.
LM EX 2(a)	1/31/01 10/31/03	Scatarige	B-Reader Board Certified	3	No abnormalities consistent with pneumoconiosis; bilateral interstitial infiltrates with honeycombing, probably due to UIP; atherosclerosis aortic arch.
LM EX 1(b)	3/15/01 10/31/03	Wheeler	B-Reader Board Certified	3	No abnormalities consistent with pneumoconiosis; interstitial infiltrates or interstitial fibrosis mixed with tiny blebs or cysts; subclavical venous catheter tip; arteriosclerosis aortic arch.
LM EX 2(b)	3/15/01 10/31/03	Scatarige	B-Reader Board Certified	3	No abnormalities consistent with pneumoconiosis; diffuse bilateral interstitial infiltrates and/or fibrosis, consistent with UIP; subclavical

¹⁰ A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. See 20 C.F.R. § 718.202(a)(1)(ii)(E)(2000) & (2001); 42 C.F.R. § 37.51. Greater weight may be accorded to the X-ray interpretation of a physician who is dually qualified as both a B-reader and board certified in radiology. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished).

					venous catheter tip; atherosclerosis aortic arch.
LM EX 1(c)	4/12/01 10/31/03	Wheeler	B-Reader Board Certified	3	No abnormalities consistent with pneumoconiosis; probable segmental atelectasis and lower left hilum; possible alveolar infiltrate in lateral periphery left mid lung; ill defined interstitial infiltrates or interstitial fibrosis mixed with tiny blebs or cysts; arteriosclerosis aortic arch.
LM EX 2(c)	4/12/01 10/31/03	Scatarige	B-Reader Board Certified	3	No abnormalities consistent with pneumoconiosis; hypoinflation in lungs; marked atherosclerotic calcification- aortic arch; bilateral pulmonary interstitial infiltrates, probably UIP.
LM EX 1(d)	4/16/01 10/31/03	Wheeler	B-Reader Board Certified	3	No abnormalities consistent with pneumoconiosis; moderate interstitial fibrosis mixed with emphysema and blebs; minimal arteriosclerosis aortic arch.
LM EX 2(d)	4/16/01 10/31/03	Scatarige	B-Reader Board Certified	3	No abnormalities consistent with pneumoconiosis; bilateral interstitial infiltrate- favor UIP; top-normal heart size; atherosclerotic calcification- aortic arch.
LM EX 1(e)	5/28/01 10/31/03	Wheeler	B-Reader Board-Certified	3	No abnormalities consistent with pneumoconiosis; moderate interstitial lung disease mixed with emphysema; top –normal heart; minimal arteriosclerosis aortic arch.
LM EX 2(e)	5/28/01 10/30/03	Scatarige	B-Reader Board Certified	3	No abnormalities consistent with pneumoconiosis; bilateral interstitial fibrosis; probably UIP; aortic atherosclerotic calcification.

The chest X-ray interpretations admitted in the survivor's claim are as follows:

Exhibit Number	Dates: X-ray/ Reading	Reading Physician	Radiological Qualifications	Film Quality	ILO Classification, Interpretation, or Impression
WM EX 3	1/31/01 10/31/03	Scott	B-Reader Board Certified	2	No abnormalities consistent with pneumoconiosis; diffuse bilateral linear interstitial infiltrates with honeycombing, likely due to UIP.
WM EX 2	4/16/01	Scatarige	B-Reader Board Certified	3	No abnormalities consistent with pneumoconiosis; bilateral interstitial infiltrate- favor UIP; top-normal heart size; atherosclerotic calcification- aortic arch.

CT Scans

A CT scan falls into the “other means” category of 20 C.F.R. § 718.304(c) rather than being considered an X-ray under § 718.304(a). A “CT,” or “CAT scan,” is “computed tomography scan or computer aided tomography scan. Computed tomography involves the recording of ‘slices’ of the body with an x-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. The technique produces an image of structures at a particular depth within the body, bringing them into sharp focus while deliberately blurring structures at other depths.” See, *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991)(citing *Bantam Medical Dictionary*, 96, 437 (Rev. Ed. 1990)). In *Consolidation Coal Co. v. Director, OWCP [Stein]*, 294 F.3d 885 (2002), the Court rejected the employer’s argument that a negative CT is conclusive evidence the miner does not have pneumoconiosis. The DOL has also rejected such a view. Nor need a negative CT be given controlling weight because the statutory definition of “pneumoconiosis” encompasses a broader spectrum of diseases than those pathological conditions which can be detected by clinical test such as X-rays and CT scans.

Since the issuance of Judge Leland’s November 19, 2001 Decision, three CT scans readings have been submitted, all of which have been read by board-certified radiologists. All three are admitted in the living miner’s claim (LM EX 4-6). One is admitted in the survivor’s claim (WM EX 5). The results of the CT scan evidence are summarized in the following table.

Exhibit Number	Dates: Scan/ Reading	Reading Physician	Findings
LM EX 4	4/16/01 10/31/03	Wheeler	Interstitial lung disease, autoimmune or UPI and moderate emphysema; no nodular infiltrates to suggest CWP; physician noted that this was an incomplete exam, which missed significant portions of the lungs.
LM EX 5; WM EX 5	4/16/01 11/3/03	Scatarige	No evidence of small round opacities to suggest CWP or silicosis; reticular interstitial infiltrates and/or fibrosis in periphery of both lungs with associated honeycombing and traction bronchiectasis- findings compatible with UIP; few top normal size lymph nodes in mediastinum, non-specific and compatible with UIP; emphysema, particularly in left lower lobe; diffuse thickening of the wall of distal esophagus, includes reflux esophagitis and lower esophageal neoplasm- suggests correlation with endoscopy or barium esophagogram.
LM EX 6	4/16/01 10/31/03	Scott	Marked diffuse linear interstitial fibrosis; probably end-stage UIP; areas of “honeycomb” lung present and scattered bullae or cysts; no evidence of silicosis/CWP.

B. Pulmonary Function Studies

Pulmonary Function Studies (“PFS”) are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV₁) and maximum voluntary ventilation (MVV).

All PFS tests of record are summarized in Judge Leland's November 19, 2001 Decision, as none have been subsequently submitted.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O₂) compared to carbon dioxide (CO₂) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

All blood gas studies of record are summarized in Judge Leland's November 19, 2001 Decision, as none have been subsequently submitted.

D. Physicians' Reports¹¹

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.204. Where total disability cannot be established under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may nevertheless be found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable gainful work. 20 C.F.R. § 718.204(b).

Since the issuance of Judge Leland's November 19, 2001 Decision, the Claimant has submitted one medical report in the survivor's claim (WM CX 1)¹² and the Employer has submitted one medical report (LM EX 11A/WM EX 10A) and four transcripts of physicians' deposition testimony (LM EX 9/WM EX 9, LM EX 10, LM EX 11B/WM EX 10B, LM EX 14). All are admitted in the living miner's claim. Dr. Renn's medical report is admitted in the survivor's claim. (WM EX 10A). The testimony of Drs. Fino (WM EX 9) and Renn (WM EX 10B) is admitted in the survivor's claim.¹³

¹¹ Under *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004), expert opinions submitted in claims governed by the post-Amendment Regulations must be based on admissible evidence. In this case, this mandate applies to medical opinions submitted in connection with the survivor's claim.

¹² I note that in its initial Evidence Designation Form for the survivor's claim, the Claimant stated that it would rely on deposition transcripts from Drs. Boustani and Rasmussen, admitted in the living miner's claim. However, the Claimant never moved for the admission of these documents in the survivor's claim. Because evidence from the living miner's claim is not automatically admitted in the survivor's claim, pursuant to *Church*, these documents are not part of the record in the survivor's claim. This ruling is distinguishable from my admission concerning the records of hospitalization and treatment in the survivor's claim, *infra*. Those records were offered for admission at the hearing and admitted because of the Claimant's adoption of them in the Evidence Designation Form. However, because the deposition transcripts were not similarly offered at the hearing, or otherwise presented to this Court, their mention in the Designation Form carries no legal effect.

¹³ 20 C.F.R. § 725.414(a)(3)(i) limits an employer to the submission of no more than two medical reports in support of its affirmative case. In the survivor's claim, the Employer has submitted one written medical report. 20 C.F.R. § 725.414(c) allows for the submission of physician testimony in lieu of a medical report. Therefore, the deposition

The Claimant submitted the March 8, 2005 report of Dr. Maria Boustani, who treated the miner for pulmonary problems. Dr. Boustani is board-certified in Internal Medicine, Critical Care and Pulmonary subspecialties. She stated that the miner “had multiple medical problems, including [chronic obstructive pulmonary disease (COPD)], chronic hypoxemia, and pneumoconiosis.” He also was chronically anticoagulated and had severe pulmonary hypertension. Dr. Boustani also reported that the miner had recurrent hospital stays related to COPD. She recalled chest X-rays taken during treatment that revealed moderate end stage pneumoconiosis and opined that the disease “had a large impact in the [miner’s] illness and ultimately his demise.” (WM CX 1).

The Employer submitted the consultative medical report of Dr. Joseph Renn, dated May 1, 2006. (LM EX 11A/WM EX 10A). Dr. Renn is board-certified in internal medicine with a subspecialty in pulmonary disease. In preparation for this report, Dr. Renn reviewed the medical examination reports of Drs. Villanueva, Starr, Craft, Zaldivar, Morgan, Daniel, Rasmussen, and Branscom, treatment records from the Southern West Virginia Clinic, Beckley-ARH Hospital, and Raleigh General Hospital, the deposition testimony of Drs. Zaldivar and Boustani, and the results of a plethora of objective medical tests, including electrocardiographs, PFS tests, blood gas studies, chest X-ray interpretations, CT scans, and an MRI. (LM EX 11A/WM EX 10A at 1-2).¹⁴ Dr. Renn noted employment and smoking histories consistent with those the miner described during his testimony before Judge Leland. (LM EX 11A/WM EX 10A at 5). After reviewing this information, Dr. Renn stated that the miner died because of progressive respiratory failure, owing to *staphylococcus aureus* bacteremia, superimposed upon acute and chronic renal failure. (LM EX 11A/WM EX 10A at 8). From a respiratory standpoint, Dr. Renn diagnosed idiopathic pulmonary fibrosis, likely usual interstitial pneumonitis (UIP), which gave rise to progressive respiratory failure and a mild restrictive ventilatory defect. (LM EX 11A/WM EX 10A at 8). Dr. Renn further stated that the miner did not have pneumoconiosis. (LM EX 11A/WM EX 10A at 8). He made additional cardiovascular, metabolic/endocrine, genitourinary, and immune system diagnoses. (LM EX 11A/WM EX 10A at 9). Dr. Renn stated that none of the conditions he diagnosed were caused or contributed to by coal dust exposure. (LM EX 11A/WM EX 10A at 9). Accordingly, Dr. Renn opined that the miner’s death was not due to his exposure to coal dust. (LM EX 11A/WM EX 10A at 9). In support of this conclusion, Dr. Renn cited several studies that did not demonstrate a link between idiopathic pulmonary fibrosis and coal dust exposure. (LM EX 11A/WM EX 10A at 9-12).

The Employer also submitted the transcript of Dr. Renn’s September 15, 2006 deposition. (LM EX 11B/WM EX 10B).¹⁵ Dr. Renn reiterated his conclusion that the miner did not have coal dust-related pneumoconiosis or lung disease. (LM EX 11B/WM EX 10B at 7-8). In support of that conclusion, he state that none of the objective medical evidence supported diagnosing the presence of such a disease. (LM EX 11B/WM EX 10B at 8). Rather, the CT

testimony of Dr. Fino is admitted in lieu of a second medical report in the survivor’s claim. Additionally, 20 C.F.R. § 725.414(c) allows for the admission of the deposition testimony of any physician who prepared a medical report. Therefore, Dr. Renn’s deposition testimony is admissible.

¹⁴ Per *Dempsey*, for the survivor’s claim, all references to evidence not introduced into the evidentiary record, and any derivative conclusions, are redacted.

¹⁵ To the degree that Dr. Renn considered evidence not admitted in the survivor’s claim, references to such evidence and any derivative conclusions are redacted as this exhibit relates to that claim.

scan evidence he reviewed was reflective of bullous emphysema and interstitial fibrosis, not CWP. (LM EX 11B/WM EX 10B at 8-9). Dr. Renn also reiterated his finding of mild restrictive ventilatory defect and stated that it was more reflective of idiopathic pulmonary fibrosis, rather than CWP. (LM EX 11B/WM EX 10B at 9-10). Dr. Renn also noted that the majority of X-ray interpretations he reviewed were negative for pneumoconiosis. (LM EX 11B/WM EX 10B at 11). Dr. Renn stated that there is no relationship between idiopathic pulmonary fibrosis and coal dust exposure. (LM EX 11B/WM EX 10B at 14-15). He also stated that the rapid progression of the miner's pulmonary disease is more reflective of idiopathic pulmonary fibrosis than CWP. (LM EX 11B/WM EX 10B at 16). Dr. Renn opined that prior to his death, the miner was unable to perform labor beyond moderate exertion; however, he stated that coal mine dust exposure did not contribute to this condition. (LM EX 11B/WM EX 10B at 21). If the miner were found to have pneumoconiosis, Dr. Renn stated that the likelihood of it being a significant contributing factor to his disability "would be slim and none." (LM EX 11B/WM EX 10B at 22). As to cause of death, Dr. Renn reiterated that the miner died due to an infection for which coal dust exposure played no role. (LM EX 11B/WM EX 10B at 25).

The Employer submitted a transcript of the April 11, 2005 deposition testimony of Dr. Ben Branscom. Although Dr. Branscom is not board-certified in pulmonology, his numerous credentials establish his expertise in the area of pulmonary disease. Dr. Branscom had previously been deposed in connection with the living miner's claim, on July 24, 2001. (LM DX 65 at 8). Since that time, he reviewed additional X-rays CT scans, and treatment and hospital records. (LM EX 14 at 12). Based on this additional evidence, Dr. Branscom concluded that the miner did not have a coal mine induced lung disease. (LM EX 14 at 14). He noted that after his first review, he left open the possibility that the miner could have had early X-ray visible pneumoconiosis. In his opinion, the more recent medical evidence foreclosed this possibility. (LM EX 14 at 14). In support of this conclusion, Dr. Branscom stated that the changes seen on the radiographic evidence in the record are not consistent with pneumoconiosis, based on location of certain changes and a lack of nodules. (LM EX 14 at 15). He also commented that the miner's diffusion impairment is not correlated with coal dust exposure. (LM EX 14 at 16). He also discounted any diagnosis of COPD, due to a lack of obstruction. (LM EX 14 at 17). Additionally, in contrast to the opinion offered at his previous deposition, Dr. Branscom opined that the miner had diffuse interstitial fibrosis. (LM EX 14 at 27). Dr. Branscom also stated that he attributed the miner's respiratory impairment to diffuse interstitial fibrosis and heart failure, not pneumoconiosis. (LM EX 14 at 46-47).

The Employer submitted a transcript of the May 24, 2006 deposition of Dr. George Zaldivar. (LM EX 10). Dr. Zaldivar is board-certified in internal medicine with a subspecialty in pulmonary diseases. (LM DX 65 at 8). Dr. Zaldivar was previously deposed in connection with the living miner's claim on August 28, 2001. (LM DX 65 at 8). During the deposition, Dr. Zaldivar reiterated his diagnosis of interstitial pulmonary fibrosis. (LM EX 10 at 4-5). He further stated that there is no correlation between that disease and coal dust exposure. (LM EX 10 at 5). He supported this assertion with references to several studies. (LM EX 10 at 5-10). With respect to the miner, Dr. Zaldivar concluded that he did not have any lung masses that arose from any occupational exposure. (LM EX 10 at 10). He characterized the miner's condition as "honeycomb lung," which is devoid of any masses that characterize pneumoconiosis. (LM EX 10 at 11). Dr. Zaldivar opined that even if the miner were found to

have some radiographic evidence of pneumoconiosis, it would not be related to his pulmonary fibrosis, which was the cause of his impairment. (LM EX 10 at 24).

The Employer submitted a transcript of the May 22, 2006 deposition of Dr. Gregory Fino. (WM EX 9/LM EX 9). Dr. Fino is board-certified in internal medicine with a subspecialty in pulmonary disease. (WM EX 9/LM EX 9 at 4). In preparation for his deposition, Dr. Fino reviewed treatment and hospital records, an unspecified number of interpretations of four chest X-rays, the CT scan interpretation by Dr. Scatarige, and a letter written by Dr. Boustani. (LM EX 9/WM EX 9 at 7-8).¹⁶ Upon reviewing these documents, Dr. Fino concluded that the miner died as a result of a pulmonary condition, which he identified as diffuse idiopathic interstitial pulmonary fibrosis representing interstitial pneumonia or pneumonitis. (LM EX 9/WM EX 9 at 8-9). (LM EX 9/WM EX 9 at 9). Dr. Fino based this diagnosis on the location of the scarring and fibrosis and Dr. Scatarige's CT interpretation of honeycombing. (LM EX 9/WM EX 9 at 15). He further noted that the timing of the miner's death, with respect to the first diagnosis a pulmonary condition, is reflective of the disease he diagnosed. (LM EX 9/WM EX 9 at 15). He had no evidence to associate this condition with coal dust exposure. (LM EX 9/WM EX 9 at 16). Indeed, Dr. Fino did not believe the miner had pneumoconiosis. (LM EX 9/WM EX 9 at 22). Therefore, Dr. Fino ultimately concluded that coal dust exposure played no role in the miner's death. (LM EX 9/WM EX 9 at 20).

III. Records of Hospitalization and Treatment

In addition to the records of hospitalization and treatment summarized in Judge Leland's decision, the evidentiary record contains records from Beckley-ARH Hospital, which span February 2, 1999-November 20, 2001. (WM DX 10).¹⁷ These records document treatment for a variety of ailments and conditions. These records contain reports of 13 chest X-rays, 7 echocardiograms, 24 physicians' opinions, 14 records of hospitalization, surgery, or emergency treatment, and one report of a CT scan of the chest.

The chest X-ray reports are summarized in the following table:

Doctor	Date	Impression
Patel	2/2/99	Mild congestive heart failure and chronic interstitial lung changes; chronic diffuse interstitial lung changes with small nodular densities, probably due to pneumoconiosis; COPD.

¹⁶ As noted above, *Dempsey* requires that medical opinions be based on admissible evidence. In the survivor's claim, only two interpretations- WM EX 3 and WM EX 2- are admitted. Therefore, although his testimony does not reveal the exact number of readings he reviewed, Dr. Fino reviewed X-ray readings in excess of those admitted in this claim. Moreover, it is unclear from his testimony if he actually reviewed the admitted readings. Therefore, for purposes of the survivor's claim, Dr. Fino's references to his consideration of X-ray evidence, and any conclusions derived from this consideration, are redacted.

¹⁷ These records were submitted to the District Director, pursuant to 20 C.F.R. § 725.405. Such evidence is not automatically forwarded to OALJ and, therefore, is not automatically admitted into the record, absent an adoption by one of the parties. See 20 C.F.R. § 725.412(b)(4)(which describes the items automatically forwarded to OALJ and does not include records of hospitalization and treatment). However, in its Evidence Designation Form, submitted to this Court, the Claimant has adopted these records; therefore, they are admitted. Neither party, however, adopted this evidence for the living miner's claim. Therefore, this exhibit is not admitted in that case. I note, though, that even if it had been admitted in the living miner's claim, the outcome would not have changed as these records contain sufficient evidence of pneumoconiosis and disability causation.

Dehgan	2/3/99	Interstitial lung disease, which needs to be clinically correlated whether due to the previous occupation or other origin; presence of mild cardiomegaly.
Dehgan	2/10/99	No evidence of active pleruoplumunary disease; changes present, which probably represent anthracosilicosis.
Patel	2/14/99	COPD with chronic parenchymal lung changes, probably due to pneumoconiosis; interval increased interstitial marking, which could be due to interstitial infiltrate.
Patel	8/24/99	Cardiomegaly with chronic parenchymal lung changes, which showed no internal change; no acute infiltrate.
Dehgan	4/28/00	Very likely represents anthracosilicosis; cardiomegaly; no evidence of acute change.
Dehgan	6/15/00	Evidence of interstitial change of the lungs consistent with lung fibrosis; normal sized to borderline cardiomegaly
Cruz	8/8/00	Pulmonary interstitial fibrosis with possibility of pneumoconiosis (based on the presence of small irregular opacities); no acute infiltrates.
Patel	12/13/00	Diffuse chronic interstitial lung changes consistent with interstitial fibrosis; COPD; no acute infiltrates.
Favelukes	12/16/00	Stable appearance of the chest.
Patel	1/31/01	Diffuse interstitial chronic lung changes, probably due to interstitial fibrosis.
Patel	4/12/01	Chronic interstitial and parenchymal lung changes consistent with interstitial fibrosis.
Cruz	5/28/01	Severe pulmonary interstitial fibrosis with probable pneumoconiosis (based on presence of small, ill-defined opacities scattered throughout).

The CT scan of the chest is dated April 16, 2001. Dr. Patel interpreted the CT scan, finding diffuse interstitial chronic changes, consistent with interstitial fibrosis, more prominent in the mid and lower lung, with honeycomb patters. He also found emphysematous bullae in both lungs.

The 24 physicians' opinions appear in either examination or consultation reports. Dr. William Powers offered a report dated February 2, 1999. Based on a chest X-ray and physical examination of the miner, his diagnosis included COPD, CWP, possible atypical pneumonia, pneumonitis with elevated white count, possible congestive heart failure, and coronary artery disease.

Dr. Thair Barghouthi offered a report dated February 5, 1999. Based on a chest X-ray, EKG, and examination of the miner, his diagnoses included congestive heart failure, probably secondary to cor pulmonale, coronary disease, and coronary atherosclerosis.

Dr. Maria Boustani offered a report dated February 6, 1999. Based on a chest X-ray and examination of the miner, her diagnosis included bilateral interstitial infiltrates, most probably secondary to pneumoconiosis.

Dr. Anthony Dinh offered a report dated February 16, 1999. Based on his physical examination of the miner, a chest X-ray, and a variety of other objective tests, Dr. Dinh's diagnosis included findings of possible sepsis, COPD with exacerbation, candida esophagitis, and coronary artery disease.

Dr. Dinh offered a report dated August 26, 1999. Based on a chest X-ray, CT scan of the head, blood gas study, and blood and urine cultures, his diagnosis included COPD with acute exacerbation.

Dr. Ashok Bhalodi offered an August 27, 1999 consultation concerning urology problems.

Dr. Powers offered an August 27, 1999 report concerning possible Parkinson's disease.

Dr. Powers offered a report dated September 7, 1999. Based on a chest X-ray and physical examination of the miner, his diagnosis included exacerbation of COPD, CWP, and he ruled out bacteremia.

Dr. Barghouthi offered a report dated December 17, 1999. Based on a physical examination of the miner, his diagnosis included COPD with acute exacerbation, hypertensive heart disease, and coronary atherosclerosis.

Dr. Ronald Green offered a report dated December 16, 1999. It arose in connection with the miner's hospitalization for breathing difficulties. Based on a physical examination of the miner, Dr. Green's diagnosis included acute exacerbation of COPD, extreme weakness of questionable etiology, and tachycardia/tachypnea.

Dr. Boustani offered a report dated December 18, 1999. Based on a physical examination and chest X-ray that showed pneumoconiosis, she prescribed continued treatment for COPD.

Dr. Powers offered a report dated April 28, 2000. Based on a physical examination of the miner, blood gas study, and other objective tests, his diagnosis included COPD with acute exacerbation and CWP.

Dr. James Yates offered a report dated August 8, 2000, which arose out of an emergency room visit for light headedness, breathing difficulties, and syncope attacks. Based on a physical examination of the miner, Dr. Yates' diagnoses included acute exacerbation of COPD, CWP, syncope, and internal carotid stenosis.

Dr. Bryan Richard offered a report dated August 10, 2000. Based on a physical examination of the miner, his diagnosis included bilateral carotid stenosis.

Dr. Barghouthi also offered a report dated August 10, 2000. Based on a physical examination of the miner, his diagnoses included syncope and a probable ischemic attack, bilateral carotid stenosis, hypertensive heart disease, and peripheral vascular disease.

Dr. Boustani offered a report dated December 13, 2000. Based on a physical examination, she admitted the miner to the hospital due to shortness of breath.

Dr. Boustani offered a report dated December 12, 2000 in connection with his hospitalization due to shortness of breath. Based on a physical examination of the miner, her diagnosis included COPD, pneumoconiosis, hypertension, and weakness.

Dr. Dinh offered a report dated December 16, 2000. Based on a chest X-ray and physical examination, his diagnoses included COPD with acute exacerbation, *staphylococcus aureus*, and pneumoconiosis.

Dr. Dinh offered a report dated January 28, 2001. Based on a physical examination of the miner, chest X-ray, and blood gas study, his diagnoses included COPD with acute exacerbation and pneumoconiosis.

Dr. Boustani offered a report dated April 12, 2001 in connection with the miner's hospitalization for febrile illness, shortness of breath, and weakness. Based on a physical examination and chest X-ray, her diagnoses included pneumonia on the right lung, and pneumoconiosis.

Dr. Barghouthi offered a report dated April 16, 2001. Based on a physical examination of the miner, his diagnoses included fever with respiratory symptoms, probably related to pneumonia, shortness of breath with edema, congested lungs consistent with congestive heart failure, and coronary atherosclerosis.

Dr. Dinh offered a report dated November 17, 2001. Based on a blood culture, recent hospitalization, physical examination, and laboratory test, his diagnoses included *staphylococcus epidermidis*, COPD, pulmonary fibrosis, and coronary artery disease.

Dr. Barghouthi offered a report dated November 18, 2001. Based on a blood culture and physical examination, his diagnoses included chest pain, probably angina pectoris, recurring septicemia, coronary atherosclerosis, and hypertensive heart disease.

Dr. Boustani offered a report dated November 15, 2001. In describing the miner's lung condition, Dr. Boustani stated that he is known to have "pulmonary fibrosis in the setting of pneumoconiosis." Based on a chest X-ray, physical examination, and blood culture, she admitted the miner to the hospital with complaints of weakness associated with significant bacteremia.

The records also contain documentation of 14 instances of hospitalization, surgery, or emergency treatment. A report of operation, dated February 10, 1999, documents surgery on this miner's esophagus.

The miner was hospitalized from February 2-February 20, 1999 for COPD with acute exacerbation. Hospital course included a chest X-ray that demonstrated diffuse interstitial infiltrates, a variety of medication, oxygen treatment, and blood and urine cultures. The miner's discharge diagnoses included acute bacterial endocarditis, COPD with acute exacerbation, pulmonary insufficiency, congestive heart failure, mitral and aortic valve insufficiency, coronary artery disease, old myocardial infarction, bacterial infection, and CWP.

The miner was hospitalized from August 24-September 11, 1999 for a variety of ailments including acute exacerbation of COPD and CWP. His treatment course included a chest X-ray, which revealed cardiomegaly and chronic parenchymal lung changes. The miner was discharged in an improved and stable condition.

The miner was hospitalized from December 16-December 19, 1999 for a variety of ailments including acute exacerbation of COPD, extreme weakness, and tachycardia/tachypnea. Based on a chest X-ray, which revealed changes consistent with pneumoconiosis and COPD, EKG, response to medication, his discharge diagnoses included that acute exacerbation of COPD and extreme weakness were resolved.

The miner was hospitalized from April 28-May 3, 2000 for COPD with exacerbation. Based on responses to medication, his discharge diagnosis included COPD with exacerbation, pneumoconiosis, and hypertension.

The miner received emergency treatment on June 15, 2000 for right flank pain. In association with that treatment, acute abd series X-rays were conducted, which were positive for pneumoconiosis.

The miner was hospitalized from August 9-August 15, 2000 due to a syncopal episode. His hospital course included an echocardiogram, chest X-ray, which showed pulmonary fibrosis, and CT scan of the chest, which showed mild peripheral cerebral atrophic changes. His discharge diagnoses included transient ischemic attack, severe carotid artery stenosis, vertebral artery stenosis, status post bacterial endocarditis, and pneumoconiosis.

The miner was hospitalized from December 13-December 15, 2000 for severe weakness and shortness of breath. His hospital course included treatment with steroids and antibiotics and a chest X-ray. His discharge diagnoses included pneumoconiosis, COPD exacerbation, and chronic pain syndrome.

The miner was hospitalized from December 12-December 27, 2000 for shortness of breath, cough, and respiratory distress. His hospital course included medication and a chest X-ray. His discharge diagnosis included *staphylococcus aureus*, bronchitis, COPD, severe bronchospasm, black lung pneumoconiosis, and generalized weakness.

The miner was hospitalized from January 27-February 3, 2001 for severe weakness and COPD exacerbation. His hospital course included a blood culture and medication. His discharge diagnosis included pneumoconiosis, COPD exacerbation, possible positive blood culture, unknown if contaminant or pathogene.

The miner was hospitalized from March 15- March 21, 2001 for severe weakness. His hospital course was marked by medication. His discharge diagnoses included pneumoconiosis with chronic bronchitis and chronic hypoxemia, severe weakness, and deconditioning.

The miner was hospitalized from April 12-April 19, 2001 for fever and leukocytosis. His hospital course included medication, echocardiogram, a blood culture, and a CT scan. His discharge diagnoses included pulmonary fibrosis, pneumoconiosis exacerbation, coronary artery disease, and severe weakness.

The miner received emergency treatment on May 28, 2001 for shortness of breath.

The miner was hospitalized from November 16-November 20, 2001 for staph bacteremia. His hospital course included an echocardiogram and stress test. His discharge diagnoses included *staphylococcus epidermis*, bacteremia, and pneumoconiosis.

IV. Witness Testimony

The Claimant, the miner's widow, testified at the hearing about her adult son, C.E., and about her husband. With respect to C.E., she testified that he currently lives at home and receives benefits from Social Security. (TR 13). The Claimant stated that C.E. currently receives treatment from a psychiatrist. (TR 14). She recalled that he dropped out of school in the tenth grade because he refused to go. (TR 15). He worked for about three years in the late 1970's but that work ended after a serious car accident. (TR 16). C.E. did not file for Social Security benefits until the mid-1990. (TR 18).

With respect to her husband, the Claimant testified that he worked in the mining industry until 1980. (TR 14). After leaving his coal mine employment, he did not work again. (TR 14). She also testified that Dr. Boustani had treated him for his breathing problems. (TR 14-15).

V. Evidence Related to the Dependency of the Miner's Adult Son

The Employer has submitted the medical records of Dr. Ahmed Faheem (LM EX 7/WM EX 7), the report of Errol Sadlon (LM EX 8/WM EX 8), and the report of Dr. John Justice (LM EX 13/WM EX 13) in support of its controversion of the dependency of the miner's adult son, C.E.

Dr. Faheen is a psychiatrist who treats C.E. (TR 14). His records document treatment from July 16, 2004-February 21, 2006. (LM EX 7/WM EX 7). Dr. Faheen made an initial diagnosis of recurrent major affective illness (depression). His records document ongoing treatment through medication and counseling. He consistently observed that C.E. had problems with depression, was "taking one day at a time," was "trying to cope," was not actively suicidal, was alert and well oriented, and had no hallucinations or delusions. (LM EX 7/WM EX 7).

The Employer submitted an April 24, 2006 rehabilitation evaluation issued by Mr. Errol Sadlon, Vocational Rehabilitation Consultant. (LM EX 8/WM EX 8). The evaluation was conducted at the request of the Employer to determine C.E.'s ability to be employed. (LM EX 8/WM EX 8 at 1). In preparation for this report, Mr. Sadlon evaluated C.E. on April 20, 2006 and reviewed various documents including the miner's black lung claim, Social Security records, CAMC records, and several clinical, psychological, and psychiatric records. (LM EX 8/WM EX

8 at 1-2). Mr. Sadlon's review of the records revealed that C.E. was involved in motor vehicle accidents in 1980, 1983, and 1986. (LM EX 8/WM EX 8 at 2). Medical records indicated that he has encountered alcoholism, breathing problems, and depression. (LM EX 8/WM EX 8 at 2). Mr. Sadlon documented several internal and external injuries that C.E. incurred as a result of his accidents. (LM EX 8/WM EX 8 at 4). C.E. reported to Mr. Sadlon that: from a physical standpoint, he could perform light work; from a psychological standpoint, he suffers from depression and poor memory; and, from a functional standpoint, he has no particular problem other than difficulty with his right hand after excessive gripping. (LM EX 8/WM EX 8 at 4).

Mr. Sadlon found no physical or psychological, age, family/social, educational, or work history factors for C.E. not to be employable. (LM EX 8/WM EX 8 at 4-9). He therefore concluded that C.E. is capable of performing work anywhere from a sedentary to light-medium level. (LM EX 8/WM EX 8 at 9). Mr. Sadlon specifically rejected C.E.'s contention that he is not employable due to psychological reasons. (LM EX 8/WM EX 8 at 10). Instead, he attributed C.E.'s unemployment to lack of motivation. (LM EX 8/WM EX 8 at 10-11).

The Employer also submitted the medical report of Dr. John Justice. (LM EX 13/WM EX 11). Dr. Justice is board certified in psychiatry and neurology. (LM EX 13/WM EX 11). In preparation for his report, Dr. Justice conducted a forensic psychiatric examination, mental status examination, and reviewed various medical records. (LM EX 13/WM EX 11 at 1). The report was prepared at the request of the Employer. (LM EX 13/WM EX 11 at 2). Like Mr. Sadlon, Dr. Justice documented C.E.'s three motor vehicle accidents and related physical problems. (LM EX 13/WM EX 11 at 3). He also documented C.E.'s ongoing difficulties with depression. (LM EX 13/WM EX 11 at 3). Dr. Justice concluded that C.E. is not permanently and totally disabled from a psychiatric perspective. (LM EX 13/WM EX 11 at 2). To that end, Dr. Justice commented that C.E. does not have major limitations with regard to social functioning, daily activities, concentration, persistence, pace, or memory that would impair him from functioning in a vocational setting. (LM EX 13/WM EX 11 at 2). Dr. Justice also stated that C.E. does not have physical difficulties that would preclude his employment, if motivated. (LM EX 13/WM EX 11 at 2). He did diagnose dysthymia, which represents a chronic depressed mood state. (LM EX 13/WM EX 11 at 7). He also diagnosed somatoform disorder NOS, which is appropriate for individuals who have physical or psychological complaints in excess of what is objectively verifiable. (LM EX 13/WM EX 11 at 7). These conditions, according to Dr. Justice, do not preclude C.E. from returning to functional employment or further education. (LM EX 13/WM EX 11 at 7).

FINDINGS OF FACT AND CONCLUSIONS OF LAW¹⁸

A. Entitlement to Benefits

These claims must be adjudicated under the Regulations at 20 C.F.R. Part 718 because they were filed after March 31, 1980. Under this Part, in a living miner's claim, a claimant must establish by a preponderance of the evidence: (1) the existence of pneumoconiosis; (2) that the

¹⁸ Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment is determinative of circuit court jurisdiction. Here, because the miner's last coal mine employment occurred in West Virginia, Fourth Circuit law controls.

pneumoconiosis arose out of coal mine employment; (3) the existence of a totally disabling pulmonary or respiratory condition; and, (4) that pneumoconiosis contributed to this totally disabling condition.

In a survivor's claim, a claimant must establish by a preponderance of the evidence, that: (1) the miner had pneumoconiosis; (2) the miner's pneumoconiosis arose out of coal mine employment; and, (3) the miner's death was due to pneumoconiosis, as provided by the Regulations. 20 C.F.R. § 718.205(a).

Failure to establish any of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Moreover, the presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet this burden. *Eastover Mining Co. v. Director, OWCP*, 338 F.3d 501 (6th Cir. 2003) (citing *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 281 (1994)).

Because the living miner's claim is the claimant's third claim for benefits, and it was filed before January 19, 2001, under the pre-Amendment version of the Regulations, the Claimant must show that there has been a material change of conditions.¹⁹ If such a change is shown, the entire record must be considered in determining whether he is entitled to benefits. In this case, as noted above, the Board affirmed Judge Leland's finding of total disability and his correlative finding of a material change in condition. For similar reasons, I also find the presence of a total disability and, thus a material change in conditions. Therefore, the entire record is considered to determine entitlement in the living miner's claim.

As noted, the living miner's claim arises as a request for modification. Under 20 C.F.R. § 725.310, a modification may be based upon a mistake of fact or a change in conditions. In this case, the Employer has based its request for modification on alleged mistakes of fact. In determining whether a mistake of fact has occurred, the Administrative Law Judge is not limited to a consideration of newly submitted evidence. All evidence of record may be reviewed to determine whether a mistake of fact was previously made. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971)(*per curiam*)(decided under the Longshore and Harbor Workers' Compensation Act). The Administrative Law Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence previously submitted." *Id.* at 257; *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1364 (4th Cir. 1996). Therefore, a complete review of the record is conducted to determine whether a mistake of fact exists.

¹⁹ Section 725.309(d) provides, in pertinent part:

In the case of a claimant who files more than one claim for benefits under this part...[i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions... (Emphasis added).

The burden of proof is on the party seeking modification to demonstrate that a mistake in determination of fact occurred. *Mitchell* at 8; *see also Branham v. Bethenergy Mines, Inc.*, 20 C.F.R. 1-27, 1-34; 20 C.F.R. § 718.403. In this case, that burden rests with the Employer.²⁰

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as “a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.” 30 U.S.C. § 902(b); 20 C.F.R. § 718.201. “Pneumoconiosis,” as considered by the Regulations, includes both a “clinical” and “legal” definition. “Clinical pneumoconiosis” includes not only CWP, but also other conditions “characterized by permanent deposition of substantial amounts of fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal miner employment.” 20 C.F.R. § 718.201(a)(1). These conditions may include, but are not limited to CWP, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silicotuberculosis arising out of coal mine employment. 20 C.F.R. § 718.201(a)(1). “Legal pneumoconiosis” is defined as “any chronic lung disease or impairment and its sequelae arising out of coal mine employment.” 20 C.F.R. § 718.201(a)(2).

The term “arising out of coal mine employment: is defined as including “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” 20 C.F.R. § 718.201(b). Thus, “pneumoconiosis,” as defined by the Act, has a much broader legal meaning than does the medical definition. As a result, conditions such as asthma, asthmatic bronchitis, emphysema, and COPD may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *See Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Warth v. S. Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of the disease: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebutable presumption for “complicated pneumoconiosis found in 20 C.F.R. § 718.304; or, (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon

²⁰ Finally, although this matter involves two claims, the doctrine of collateral estoppel shall not apply. Under that doctrine, once an issue is actually and necessarily decided by a court of competent jurisdiction, that determination is conclusive in subsequent suits based on different causes of action that involve the same parties, or those in privity. *Collins v. Pond Creek Mining Co.*, Case No. 05-1832 at 5(4th Cir. Nov. 8, 2006) (citing *Montana v. United States*, 440 U.S. 147, 153 (1979)). However, to apply collateral estoppel, five elements must be established: (1) that the issue sought to be precluded is identical to the one previously litigated; (2) that the issue was actually determined in the prior proceeding; (3) that the issue’s determination was a critical and necessary part of the decision in the prior proceeding; (4) that the prior judgment is final and valid; and, (5) that the party against whom collateral estoppel is asserted had a full and fair opportunity to litigate the issue in the previous forum. *Collins*, at 6 (citing *Sedlack v. Braswell Servs. Group, Inc.*, 134 F.3d 219, 224 (4th Cir. 1998)(quotations omitted). Here, collateral estoppel does not apply because the issues common to both claims were not finally decided in a prior proceeding. To elaborate, although certain such issues were decided in a prior proceeding, within the context of this case, those determinations were not final. Second, to the degree that certain issues are “finally” decided in one claim here, those decisions do not apply to the other claim under the doctrine because these determinations were not made in a prior proceeding.

certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the Court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997), which requires the same analysis.

1. *Living Miner's Claim*

At the outset, it is important to note the effect of the Board's decision on the issue of existence of pneumoconiosis in the living miner's claim. As noted, the Board rejected the Employer's objections to Judge Leland's weighing of the X-ray evidence. Judge Leland found the X-ray evidence, as a whole, to be highly contradictory, but based his finding of the existence of pneumoconiosis, in part, on that X-ray evidence. At first blush, the Board's upholding of this conclusion would be entitled to "law of the case" treatment. The rule of the "law of the case" is a rule of practice that once an issue is litigated and decided, it should not be relitigated. *See United States v. U.S. Smelting, Refining, and Mining Co.*, 339 U.S. 186 (1950). However, the rule does not apply in the face of a specific exception. *See Brinkley v. Peabody Coal Co.*, 14 B.L.R. 1-47 (1991)(applying the rule in the absence of such an exception). In *Mitchell v. Daniels Co.*, BRB Nos. 01-0364 & 03-0134 BLA (BRB Feb. 12, 2004)(unpub.), the Board held that modification presents such an exception to the "law of the case" doctrine. *Mitchell* at 11. To that end, the Board explained that modification, by its nature, does not implicate general principles of finality. *Id.* In addressing a situation analogous to this case, the Board stated that where it affirms some findings but remands the entire case, and a party subsequently moves for modification, the affirmed findings are not binding as the law of the case. *Id.*²¹ Therefore, in this case, the Board's favorable treatment of Judge Leland's consideration of the X-ray evidence is not binding in addressing whether the miner had pneumoconiosis.

In his May 5, 2003 Decision and Order on Remand, Judge Leland found the existence of pneumoconiosis based on a weighing of the chest X-ray, CT scan, and medical opinion evidence. Specifically, with respect to the X-ray evidence, Judge Leland noted that eight dually qualified physicians,²² one practicing radiologist/B-reader, one board-certified radiologist, and two B-readers determined that there is evidence of pneumoconiosis; conversely, four dually qualified physicians, a formerly certified B-reader, and a B-reader who had previously provided a positive X-ray, found no radiographic evidence of pneumoconiosis. (LM DX 85 at 2). With respect to the CT scan evidence, Judge Leland found that, although four out of five reading physicians interpreted the March 14, 2000 CT scan as negative, this fact paled in comparison to the positivity of the X-ray evidence. (LM DX 85 at 2). Finally, with respect to the medical opinion

²¹ It should be noted that the Board's statement constituted *dicta* in that case as the actual issue under consideration involved the effect of a stipulation.

²² A "dually qualified physician" is both a B-reader and board-certified radiologist.

evidence, Judge Leland credited the opinions of Drs. Daniel, Starr, Craft, Rasmussen, and Boustani and the West Virginia Occupational Pneumoconiosis Board; conversely, he discredited Dr. Zaldivar's opinion as inconsistent and Dr. Branscom's opinion as equivocal. (LM DX 85 at 2-3). In weighing this evidence together, consistent with the Fourth Circuit's mandate in *Island Creek*, Judge Leland concluded that the miner had pneumoconiosis. (LM DX 85 at 3).

As detailed above, in furtherance of its petition for modification, the Employer has submitted ten additional negative chest X-ray interpretations, three additional negative CT scan interpretations, one additional medical report and the transcripts of four physicians' depositions. In considering this new evidence, along with the evidence submitted previously, I find that the Employer has not established a mistake of fact with respect to the existence of pneumoconiosis.

First, I find that the chest X-ray evidence continues to support the existence of pneumoconiosis. While this case was pending before Judge Leland, the majority of the readings were negative for pneumoconiosis. The ten additional negative readings widen the gap between the number of negative and positive readings. However, numerical superiority need not be treated dispositively as to the presence or absence of pneumoconiosis. *See Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990); *cf. Edmiston v. F & R Coal Co.*, 14 B.L.R. 1-65 (1990)(holding, however, that it is within the Administrative Law Judge's discretion to do so).²³ Correspondingly, increased numerical superiority need not be treated dispositively in finding mistake of fact concerning the existence of pneumoconiosis. In this case, I decline to accord numerical superiority dispositive treatment, given that the majority of most qualified physicians have found radiographic evidence of pneumoconiosis.

To that end, of the ten new X-ray readings, Dr. Wheeler provided five and Dr. Scatarige provided five. Both are dually qualified physicians. Dr. Wheeler offered several interpretations prior to modification; these are the first interpretations offered by Dr. Scatarige in connection with this case. Therefore, in updating the statistics Judge Leland provided, the only change is that five dually qualified physicians have found no radiographic evidence of pneumoconiosis, as opposed to four. Accordingly, the eight dually qualified physicians who found radiographic evidence of pneumoconiosis continues to outweigh the countervailing X-ray evidence. As such, the Employer has not established a mistake of fact with respect to the X-ray evidence of record.

The Employer also has not established a mistake of fact with respect to the CT scan evidence. By providing three readings of an additional CT scan that lacked evidence of pneumoconiosis, the Employer has moderately strengthened the CT evidence as countervailing to the existence of pneumoconiosis. However, I find, similarly to Judge Leland, that this evidence pales in comparison to the chest X-ray evidence, which is predicated upon greater numbers of readings, physicians, and a greater span of time. Therefore, the Employer has established no mistake of fact with respect to the CT scan evidence.

Finally, the Employer also has not established a mistake of fact with respect to the medical report evidence.

²³ Indeed, the Fourth Circuit has looked upon the dispositive treatment of numerical superiority with disfavor. *See Adkins v. Director, OWCP*, 958 F.2d 49, 52 (4th Cir. 1992); *Copley v. Arch of West Virginia, Inc.*, Case No. 93-1940 (4th Cir. June 21, 1994)(unpub.).

To be credited, a medical report must be both well-documented and well-reasoned. A “documented” report sets forth the clinical findings, observations, and facts on which the doctor has based the diagnosis. *Fields v. Director, OWCP*, 10 B.L.R. 1-19 (1987). A report is “reasoned” if the documentation supports the doctor’s assessment of the miner’s health. *Id.* Upon finding a medical report to be unreasoned, an Administrative Law Judge may reject it entirely or accord it diminished weight in crediting its conclusions. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989). Medical reports may be rejected or accorded diminished weight for a variety of other reasons. One such basis is if the opinion is equivocal. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988). An opinion may also be discredited if it is internally inconsistent. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986). It may also be discredited if one report is inconsistent with a prior report or testimony submitted by the same physician in a particular case, particularly if the physician does not adequately explain the discrepancy. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984).

For reasons similar to Judge Leland’s, namely that they are well documented and well reasoned, I credit the medical opinions of Drs. Starr, Craft, Rasmussen, Boustani, and the West Virginia Pneumoconiosis Board, each of which supports the presence of pneumoconiosis.

I accord Dr. Branscom’s opinion diminished weight. As Judge Leland noted in his initial Decision, Dr. Branscom initially stated that he was unable to determine whether the miner had pneumoconiosis when he left the mines but believed that his later abnormalities did not evidence the presence of the disease. (LM DX 66 at 7). In his Decision and Order on Remand, Judge Leland ultimately found this opinion to be equivocal. (LM DX 85 at 3). In his most recent deposition, Dr. Branscom stated that, despite his earlier reluctance to foreclose the possibility of pneumoconiosis, he could now rule it out based on a review of additional X-ray and CT scan evidence. (LM EX 14 at 14). Dr. Branscom’s retraction of his initial opinion, however, is poorly documented and, correspondingly, poorly reasoned. To that end, Dr. Branscom did not set forth what specific X-ray interpretations led him to now foreclose the possibility of pneumoconiosis. As a result, Dr. Branscom has not sufficiently explained how this new evidence gave rise to an altered conclusion; thus this opinion is unreasoned. As a result, Dr. Branscom’s overall opinion remains equivocal, as it was while the case was pending before Judge Leland.

I also accord Dr. Zaldivar’s opinion diminished weight. As Judge Leland explained, Dr. Zaldivar previously opined both that the miner had radiographic evidence of pneumoconiosis and that he only had radiographic evidence of pulmonary fibrosis. (LM DX 65 at 11). He then testified that the miner may have pneumoconiosis. (LM DX 66 at 11). In his most recent testimony, Dr. Zaldivar discussed various pieces of medical evidence that reviewed and how none supported a finding of an obstructive impairment due to coal dust exposure. (*See generally* LM DX 10). He also stated that he did not believe the miner had CWP. (LM DX 10 at 54). Therefore, Dr. Zaldivar’s most recent testimony supports the conclusion that the miner did not have pneumoconiosis. As such, it is inconsistent with his prior reports and testimony and, as a result, his opinion as a whole is internally inconsistent. Moreover, he did not sufficiently explain the inconsistencies that occurred over time. Therefore, his opinion is entitled to diminished weight.

I accord Dr. Fino's opinion diminished weight as to the existence of pneumoconiosis due to poor documentation. As noted above, Dr. Fino concluded that, based on the medical evidence he reviewed, the miner did not have pneumoconiosis. (LM EX 9/WM EX 9 at 22). Dr. Fino based this conclusion upon, *inter alia*, a review of an unspecified number of interpretations of four X-rays. (LM EX 9/WM EX 9 at 8). By not specifying which, or how many, readings he reviewed, Dr. Fino has not adequately set forth his factual basis for arriving at this conclusion. This defect is particularly noteworthy in this case, where I have concluded that the voluminous record of X-ray evidence supports a finding of pneumoconiosis. Indeed, because of Dr. Fino's poor documentation, it is unclear the degree to which radiographic evidence played a role in his conclusion; thus, his opinion may not be adequately weighed against the X-ray evidence of record, as required by *Island Creek*. Therefore, I accord his opinion diminished weight in determining whether the miner had pneumoconiosis.

Finally, I accord Dr. Renn's opinion moderately diminished weight, because his conclusion concerning the radiographic evidence of pneumoconiosis is inconsistent to with my decision. Dr. Renn found that the radiographic evidence did not support a finding of CWP and premised this conclusion on the fact that a majority of the interpretations he reviewed were negative. (LM EX 11B/WM EX 10B at 10-11). Thus, Dr. Renn has, *inter alia*, credited the numerical superiority of negative readings in arriving at his conclusion. As explained above, I have declined to accord the numerical superiority of the negative readings dispositive treatment in this case. Thus, Dr. Renn's approach in evaluating the radiographic evidence is inconsistent with the approach taken by this Court. Still, I find Dr. Renn's opinion to be both well documented and well reasoned. Moreover, my discrediting of his opinion is tempered because Dr. Renn considered the presence of positive X-ray readings in arriving at his conclusions. Thus, while I accord his opinion diminished weight, this diminishment is only moderate.

In weighing the chest X-ray, CT scan, and medical opinion evidence of record in the living miner's claim, I find that the miner had pneumoconiosis. To that end, the X-ray evidence and credited medical opinions outweigh the negative CT scan evidence and relatively discredited medical opinions. I further note that the type of pneumoconiosis I find is clinical. Although there is evidence of various conditions that may give rise to a finding of legal pneumoconiosis, there is insufficient evidence that links these conditions to coal dust exposure. Therefore, the Claimant has established the first element of entitlement in the living miner's claim by demonstrating the existence of clinical pneumoconiosis.

2. Survivor's Claim

At the outset, I note the relative paucity of evidence, both quantitatively and qualitatively, contained in the survivor's claim, when compared with the living miner's claim, toward the existence of pneumoconiosis. The totality of this evidence, however, establishes the presence of the disease.

The chest X-ray evidence does not support the presence of pneumoconiosis. The record contains 15 chest X-ray interpretations, two of which were submitted by the Employer as

affirmative evidence (WM EX 3 & WM EX 2) and thirteen of which were part of the records of hospitalization and treatment adopted by the Claimant (WM DX 10).

20 C.F.R. § 718.102(b) requires that the results of chest X-rays be reported according to the ILO-U/C International Classification of Radiographs. 20 C.F.R. § 718.102(e) states that, save certain exceptions, no chest X-ray shall constitute evidence of the presence or absence of pneumoconiosis unless it is reported in accordance with these requirements. This standard, however, is subject to the umbrella “substantial compliance” qualification, which applies to all evidence submitted under Part 718, and states that “[a]ny clinical test or examination subject to these standards shall be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered.” 20 C.F.R. § 718.101(b).²⁴ Therefore, evidence that “substantially complies” equates with evidence that strictly complies. In codifying the “substantial compliance” qualification, the Department of Labor’s Drafters Comments put forth the following test for the adjudicator to conduct in determining whether evidence substantially complies with the applicable quality standard:

In each case in which an issue of noncompliance is raised, the factfinder must identify any failure to comply strictly with the applicable quality standard. The factfinder must then determine whether the test or report is reliable despite its failure to comply with every criterion in the standard. This finding is necessarily dependent to an extent on the element(s) of entitlement for which the test or report may be relevant. The significance of the particular defect must therefore be ascertained by whether it is critical to the physician’s conclusions. Federal Coal Mine Health and Safety Act of 1969, as Amended, 65 Fed. Reg. 245, 79928.

Therefore, the focus of my inquiry is twofold: (1) First, I must ascertain what element of the proffered evidence deviates from strict compliance with the Regulations; and, (2) Second, I must then determine if that deviance bears adversely on the reliability of the evidence, given its significance to the claim.²⁵ If the deviance renders the piece of evidence unreliable, then the evidence is nonconforming and correspondingly inadmissible. If, however, the deviance does not render the evidence unreliable, then the evidence substantially complies with the regulations and should be admitted.

In this case, the thirteen X-ray interpretations admitted as part of the records of hospitalization and treatment do not strictly comply with the requirements of § 718.102(b). Specifically, the results of these X-rays are not reported according to the ILO-U/C classification system. However, because these X-rays were conducted, reported, and analyzed as part of the miner’s ongoing course of pulmonary treatment, I find that this noncompliance does not

²⁴ See also Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 62 Fed. Reg. 14, 3342 (proposed January 22, 1997) (to be codified at 20 C.F.R. pt. 718) (stating, “[§ 718.102(e)] should be reorganized in view of the proposed paragraph 718.101(b) general compliance standard. [W]ith respect to proposed paragraph 718.101(b), codifying the “substantial compliance” standard in that regulation of general applicability eliminates the need to reiterate it in each specific quality standard.”).

²⁵ The Drafter’s Comments speak further to the point of reliability, stating, “For the purpose of the quality standards, ‘substantial reliance’ may mean less than strict compliance with each and every requirement of the applicable quality standard if the evidence is nevertheless deemed reliable by the factfinder.” Federal Coal Mine Health and Safety Act of 1969, as Amended, 65 Fed. Reg. 245, 79929.

adversely affect their reliability. Therefore, I find that they substantially comply with the quality standards of § 718.102(b) and, thus, shall be considered in determining the existence of pneumoconiosis in the survivor's claim.

That said, the X-ray readings contained in WM DX 10 provide only minimal support for the existence of pneumoconiosis. Of the thirteen, seven do not include a finding of pneumoconiosis; accordingly, these readings do not support a finding of pneumoconiosis. Those that do offer evidence of pneumoconiosis do so equivocally. Specifically:

- (a) Dr. Patel's February 2, 1999 reading stated that the changes he found were "probably due to pneumoconiosis;"
- (b) Dr. Dehgan's February 10, 1999 reading stated that the changes present "probably represent anthracosilicosis."²⁶
- (c) Dr. Patel's February 14, 1999 reading stated that certain changes were "probably due to pneumoconiosis."
- (d) Dr. Dehgan's April 28, 2000 report stated that his findings "very likely [represent] anthracosilicosis."
- (e) Dr. Cruz's August 8, 2000 reading included a "possibility of pneumoconiosis."
- (f) Dr. Cruz's May 28, 2001 reading found "probable pneumoconiosis."

Due to the equivocality of these readings, I accord each diminished weight. Therefore, each supports the presence of pneumoconiosis minimally.²⁷

The Employer had submitted two properly classified chest X-ray interpretations, both of which are negative for the existence of pneumoconiosis. (WM EX 2; WM EX 3). These X-ray interpretations outweigh the minimally credited readings from WM DX 10. Therefore, the X-ray evidence in the survivor's claim, as a whole, does not support the existence of pneumoconiosis.

The medical report evidence of record in the survivor's claim also does not support the presence of the disease. Dr. Boustani's report (WM CX 1) is poorly documented. Specifically, she stated that she provided ongoing treatment to the miner and that he had pneumoconiosis. In support of this assertion, Dr. Boustani said that chest X-rays conducted as part of her treatment routinely produced readings of pneumoconiosis. Dr. Boustani, however, did not identify any such specific chest X-rays. Similarly, Dr. Boustani has not supported her finding of COPD with

²⁶ It should be noted that a finding of anthracosilicosis, combined with over ten years of coal mine employment, can constitute evidence of clinical pneumoconiosis under 20 C.F.R. § 718.201(a)(1). *See Hapney v. Peabody Coal Co.*, 22 B.L.R. 1-106 (2001)(en banc)(ruling that evidence of anthracosis, may qualify in this manner. Like anthracosis, anthracosilicosis is listed in § 718.201(a)(1).

²⁷ I also note that some of X-ray readings contained in the hospitalization and treatment records find COPD. However, the record lacks evidence linking this COPD to coal mine employment. Therefore, these readings do not support a finding of legal pneumoconiosis.

objective information.²⁸ Therefore, because she did not document the specific objective evidence upon which her conclusion was based, I accord it minimal weight.

The two medical opinions submitted by the Employer also exhibit documentation defects. As noted above, the opinions offered by Drs. Renn and Fino each reference a substantial amount of evidence that is not admitted in the survivor's claim. These references, and corresponding derivative conclusions, have been redacted. As a result, both opinions lack optimal documentation in support of their respective conclusions. I accord each diminished weight as a result.

In considering the totality of the medical opinion evidence, I find insufficient evidence to support the existence of pneumoconiosis. Although all three opinions have been accorded diminished weight, the burden remains with the Claimant to affirmatively establish the presence of the disease. The medical opinion evidence, as a whole, fails to do so.

The records of treatment and hospitalization, however, do support a finding of pneumoconiosis. As noted, the record in the survivor's claim documents such treatment from February 1999-November 2001, a period within a close proximity to the miner's death. Of the 24 examination or consultation opinions offered in connection with this treatment, 11 include findings of pneumoconiosis. Of these 11, eight base this finding on both a physical examination of the miner and a chest X-ray and three base this finding solely on a physical examination. Of the 14 reports of hospitalization, surgery, or emergency treatment, 12 include diagnoses of pneumoconiosis. Of these twelve, two base this finding solely on a chest X-ray, five do not include an X-ray but rely on various other types of treatment, and five consider both an X-ray and other types of treatment in arriving at this diagnosis. Therefore, despite my misgivings concerning the X-ray readings included in the hospitalization and treatment records, I find these conclusions to be sufficiently documented because of the consistent reliance on other evidence in addition to the chest X-rays in finding pneumoconiosis. While I find the reasoning of these records to lack the syllogistic detail of comprehensive medical report, I note that these opinions arose in the context of treatment, not litigation. Thus, this defect does not prove fatal in crediting their conclusions. Moreover, I find that the consistency of opinion among different physicians, the substantial number of reports, and prolonged timeframe of the records makes up for any defect in reasoning. Therefore, I credit these records toward the existence of pneumoconiosis.

Finally, I note that the death certificate in this case listed pneumoconiosis as a cause of death. (WM DX 9). Accordingly, it supports the existence of pneumoconiosis. However, a death certificate, in and of itself, neither proves nor disproves the presence of pneumoconiosis. *Pettit v. Director, OWCP*, Case No. 94-1927 at 3 (Feb. 23, 1995)(unpub.). Rather, its conclusion shall be credited or discredited with reference to other facts presented in the case. *Id.* Whether or not the conclusion offered on the death certificate was made with reference to autopsy conclusions is of particular importance. *Id.*; accord, *Risher v. Director, OWCP*, 940 F.2d 327, 331 (8th Cir. 1991). In this case, because no autopsy was performed, the conclusions listed on the death certificate did not reflect autopsy findings. (see WM DX 9). As a result, I accord these conclusions minimal weight toward the existence of pneumoconiosis.

²⁸ Moreover, there is no evidence linking her finding of COPD to coal mine employment.

Therefore, in weighing the evidence of record in concert, as required by *Island Creek*, I find that the Claimant has again established the existence of pneumoconiosis. Notably, the most credited evidence toward this issue is the two negative X-rays submitted by the Employer and the opinions within the records of hospitalization and treatment submitted by the Director and adopted by the Claimant. I find that the latter outweighs the former, based on the numerosity of opinions and the fact that they were offered by physicians engaged in regular treatment of the miner. Moreover, the remaining minimally credited evidence does not disturb this conclusion. Therefore, the Claimant has established the first element of entitlement in the survivor's claim.

C. Cause of Pneumoconiosis

Once a miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for at least ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent medical evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Because the miner had 34 years of coal mine employment, he receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. Additionally, the record does not contain any contrary evidence that establishes that his pneumoconiosis arose out of alternative causes. Therefore, the Claimant has established this element of entitlement. This finding applies to both the living miner's and survivor's claims.

D. Existence of Total Disability

In the living miner's claim, the Claimant must show that he has a totally disabling pulmonary or respiratory impairment. 20 C.F.R. § 718.204. Section 718.204(b)(2)(i) through (b)(2)(iv) and (d) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevented him from engaging in his usual coal mine employment and gainful employment requiring comparable abilities and skills; and lay testimony.

In his initial decision, Judge Leland found that the miner had established the presence of a total disability. He based this finding on the presence of qualifying blood gas studies and the opinions of Drs. Rasmussen, Zaldivar, Boustani, and Branscom, and the records of hospitalization and treatment. (LM DX 65 at 10). I agree with Judge Leland's conclusions, and similarly find that this evidence supports a finding of total disability. Moreover, the evidence submitted since the Employer's petition for modification provides no countervailing evidence.²⁹

²⁹ Dr. Renn stated that, because of his condition, the miner was unable to perform labor beyond a moderate exertion. (LM EX 11B/WM EX 10B at 21). Based on his testimony before Judge Leland, however, I find that the miner's

Therefore, the totality of the evidence submitted in connection with the living miner's claim establishes that the miner had a total disability.

E. Cause of Total Disability

To establish disability causation, a miner must establish that he is totally disabled due to pneumoconiosis such that that disease is a "substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment." 20 C.F.R. § 718.204(c)(1)(2001).³⁰ Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

- (1) has a material adverse effect on the miner's respiratory or pulmonary condition; or
- (2) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal miner employment. 20 C.F.R. § 718.204(c)(1)(ii) & (ii).

The Fourth Circuit has interpreted this element to require that pneumoconiosis be a "contributing cause" of the miner's total disability. *Toler v. E. Assoc. Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995).

In his initial decision, Judge Leland found that the miner has established the element of disability causation based on his crediting of Drs. Rasmussen and Boustani and discrediting of Drs. Zaldivar and Branscom. (LM DX 66 at 11-12). After the Board affirmed this finding, Judge Leland reiterated it in his decision on remand. (LM DX 85 at 3). I concur with Judge Leland's findings concerning this evidence as it relates to the issue of disability causation.

Moreover, none of the evidence submitted subsequent to the Employer's petition for modification supports an alternate finding. Specifically, I accord the recently submitted opinions of Drs. Renn, Fino, Zaldivar, and Branscom minimal weight as to disability causation because each is based on the opinion that the miner did not have pneumoconiosis.

The Fourth Circuit addressed this situation in *Toler*. In that case, the Administrative Law Judge found that the claimant had established the presence of pneumoconiosis but not total disability due to pneumoconiosis. As support for the latter, the Administrative Law Judge relied upon medical reports that diagnosed no pneumoconiosis. The Fourth Circuit vacated this decision, describing this rationale as "paradoxical reasoning." *Toler*, 43 F.3d at 115.³¹ The Fourth Circuit further explained that such an opinion deserves no credit unless the Administrative Law Judge can identify how the opinion on disability causation does not rest on a finding of no pneumoconiosis. *Id.* at 116. In this case, I find that all four recently submitted

usual coal mine employment involved heavy labor. (See LM DX 65 at 25). Therefore, Dr. Renn's opinion supports a finding of total disability.

³⁰ The Amended version of this provision, as is true of all of § 718 save one sentence, applies to claims filed before and after January 19, 2001. 20 C.F.R. § 718.2 (2001).

³¹ The Court explained that "it is difficult to understand how the ALJ could have credited their conclusions as to causation while simultaneously finding that [the claimant] suffers from pneumoconiosis." *Id.*

opinions that counter a finding of disability causation specifically rest on a finding of no pneumoconiosis. Therefore, pursuant to *Toler*, they may not be credited on this issue.

Therefore, in considering all of the evidence submitted in the living miner's claim, the miner has established that pneumoconiosis substantially contributed to his total disability. Correspondingly, the Employer has not established a mistake of fact as to this issue. Therefore, the miner has established this element of entitlement.

F. Death Due to Pneumoconiosis

In the survivor's claim, the Claimant must establish that the miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

- (1) competent medical evidence established that the miner's death was caused by pneumoconiosis; or
- (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death of the death was caused by complications of pneumoconiosis; or
- (3) the presumption of § 718.304 [complicated pneumoconiosis] is applicable.

Because the record contains no evidence of complicated pneumoconiosis, the Claimant may only establish this element pursuant to the first two prongs of the above standard. The evidence of record, however, is insufficient to do so.

The only evidence of record that supports a finding of death due to pneumoconiosis is the death certificate (WM DX 9) and Dr. Boustani's report (WM CX 1). I accord the death certificate minimal weight as its conclusions are not supported by other evidence, namely the results of an autopsy.³²

I also accord Dr. Boustani's report minimal weight toward the issue of cause of death. In her report, Dr. Boustani commented that "[Pneumoconiosis] has a large impact on the patient's illness and ultimately his demise." (WM CX 1). She, however, offered no factual basis or rationale for arriving at this conclusion. Therefore, her report is both undocumented and unreasoned and is therefore discredited.

I also accord the opinions of Drs. Renn and Fino minimal weight as to cause of death for reasons analogous to my discrediting their opinions as to disability causation in the living miner's claim. Specifically, I find that their conclusions that the miner's death was not caused by pneumoconiosis to be based on their findings of no pneumoconiosis. Therefore, in drawing parallels to *Toler*, I do not accord them credit on this issue.

³² See *supra*, "Existence of Pneumoconiosis."

As noted, however, the Claimant has the burden of establishing this element of entitlement. Because no credible evidence of record established that the miner's death was due to pneumoconiosis, the Claimant has not established this element of entitlement.

G. Dependency of Miner's Adult Son

The Employer has alleged a mistake of fact in Judge Leland's finding that the miner's adult son, C.E., is disabled for the purposes of benefits augmentation. In his decision on remand, Judge Leland based his finding on C.E.'s Social Security award and the miner's testimony. (LM DX 85 at 3-4). The Employer requested a reconsideration of this issue, asserting that Judge Leland gave dispositive treatment to the Social Security award. Judge Leland reconsidered his decision and declined to disturb it, explaining that he found the Social Security award to be persuasive, not conclusive. (LM DX 86 at 2).

An award of benefits may be augmented to a dependent child of the award's beneficiary- i.e. the miner's or surviving spouse. 20 C.F.R. § 725.208-209. To be considered a "dependent child," the individual must satisfy both relationship and dependency criteria. *See* 20 C.F.R. § 725.208-209. The individual satisfies the relationship criteria if he is considered to be child of the beneficiary pursuant to the laws of the state where the beneficiary is domiciled. 20 C.F.R. § 725.208(a). To meet dependency criteria, the individual must be:

(1) unmarried; and

(2) (i) under 18 years of age; or

(ii) is under a total disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. § 423(d); or

(iii) is 18 years of age or older and is a student.

Section 223(d) of the Social Security Act defines disability as "the inability to engage in substantial activity by reason of any medically determinable physical or mental impairment...." 42 U.S.C. § 423(d)(1)(A). The Board has explained that the focus of this inquiry is whether the individual alleged to be disabled could perform gainful work. *Scalza v. Director, OWCP*, 6 B.L.R. 1-1016 (1983).³³

In this case, it is not contested, and I find, that C.E. is the child of the miner and his widow. Therefore, he meets the relationship criteria. The focus of this inquiry, however, is on the dependency test, specifically, if C.E. is totally disabled as required by the Regulations. The weight of the evidence reveals that he is not.

The professional evidence of record establishes that, despite the presence of a mental impairment, C.E. is able to perform gainful work. Both Mr. Sadlon and Dr. Justice considered

³³ *Scalza* arose in the context of determining an adult child's entitlement to benefits as a surviving dependent, not, as in this case, for the purposes of benefits augmentation. The distinction, however, is immaterial as its holding pertained to the same factual inquiry presented here.

various records pertaining to the C.E.'s mental condition and concluded that he is capable of performing work. (LM EX 8/WM EX 8 at 9; LM EX 13/WM EX 11 at 7). The record contains no countervailing professional evidence. Moreover, the opinions of these professionals outweigh the Social Security award and the testimony of the miner concerning his son. To that end, the Social Security award conclusorily stated that C.E. is disabled; however, it did not provide a factual rationale in support. (See LM DX 10; WM DX 8). Therefore, I accord it minimal weight in determining whether the adult son is disabled for the purposes of the Act. Additionally, with respect to the miner's testimony, the miner merely stated that his son is disabled and reported that he is receiving Social Security benefits for his disability. (LM DX 65 at 22). There are again no factual underpinnings for these assertions.

Therefore, I find that the weight of the evidence establishes that the adult son, C.E., is not totally disabled as defined by the Regulations. As a result, the Employer has established a mistake in determination of fact with respect to the adult son's dependency in the living miner's claim. Moreover, the Claimant has not established the adult son's dependency in the survivor's claim. Therefore, benefits shall not be augmented under the Act.

H. Date of Entitlement

Benefits are payable beginning with the month of the onset of total disability due to pneumoconiosis. 20 C.F.R. § 725.503. Judge Leland found the onset date to be October 1, 1999. I agree with Judge Leland and similarly find the onset date to be October 1, 1999. Therefore, Claimant is entitled to benefits in the living miner's claim from October 1, 1999-March 31, 2002.³⁴

ATTORNEY FEES

An application by the claimant's attorney for approval of fees has not been received; therefore, no award of an attorney's fees for services is made. Thirty days is hereby allowed to the claimant's counsel for the submission of such an application. Counsels' attention is directed to 20 C.F.R. §§ 725.365-366. A service sheet showing that service has been made upon all parties, including the claimant, must accompany the application. Parties have ten days following receipt any such application within which to file objections. The Act prohibits charging a fee in the absence of an approved application.

CONCLUSIONS

In the living miner's claim, the Employer has not established a mistake in the determination of fact. Correlatively, with respect to that claim, I find that the miner had pneumoconiosis, that his pneumoconiosis arose out of coal mine employment, that he was totally disabled, and that pneumoconiosis contributed to his disability. Therefore, the Claimant is entitled to benefits in the living miner's claim. In the survivor's claim, I again find that the miner had pneumoconiosis, which arose out of coal mine employment. However, the Claimant has not established that the miner's death was due to pneumoconiosis. Therefore, the Claimant

³⁴ Because the miner died on April 7, 2002, benefits shall be paid through March 2002. See 20 C.F.R. § 725.502(c) ("Benefit payments shall terminate with the month before the month during which eligibility terminates.").

is not entitled to benefits in the survivor's claim. Additionally, the Employer has established a mistake in fact with respect to the dependency of the miner's adult son, C.E. Therefore, benefits awarded in the living miner's claim shall not be augmented to C.E.

ORDER

THEREFORE, it is hereby ORDERED that the living miner's claim of W.J.E. for benefits under the Act is GRANTED. It is further ORDERED that the survivor's claim of V.M.E. for benefits under the Act is DENIED. It is further ORDERED that benefits awarded are NOT AUGMENTED for the miner's adult son, C.E.

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RICHARD A. MORGAN
Administrative Law Judge

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (Effective Jan. 19, 2001): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**³⁵

At the time you file an appeal with the Board, you **must also send a copy** of the appeal letter to **Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210.** See 20 C.F.R. § 725.481.

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

³⁵ 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

E-FOIA Notice: Under e-FOIA, final agency decisions are required to be made available via telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. § 552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). Although 20 C.F.R. § 725.477(b) requires decisions to contain the names of the parties, it is the policy of the Department of Labor to avoid use of the Claimant's name in case-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an appeal is taken to the Benefits Review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.